Early Journal Content on JSTOR, Free to Anyone in the World

This article is one of nearly 500,000 scholarly works digitized and made freely available to everyone in the world by JSTOR.

Known as the Early Journal Content, this set of works include research articles, news, letters, and other writings published in more than 200 of the oldest leading academic journals. The works date from the mid-seventeenth to the early twentieth centuries.

We encourage people to read and share the Early Journal Content openly and to tell others that this resource exists. People may post this content online or redistribute in any way for non-commercial purposes.

Read more about Early Journal Content at http://about.jstor.org/participate-jstor/individuals/early-journal-content.

JSTOR is a digital library of academic journals, books, and primary source objects. JSTOR helps people discover, use, and build upon a wide range of content through a powerful research and teaching platform, and preserves this content for future generations. JSTOR is part of ITHAKA, a not-for-profit organization that also includes Ithaka S+R and Portico. For more information about JSTOR, please contact support@jstor.org.

STANDARDS OF SICKNESS INSURANCE. II

Kinds of benefit.—The direct object of sickness insurance is the complete or at least partial restitution of the losses sustained through sickness. This demands two broad divisions of service: (1) a money benefit during loss of earning power; (2) restitution of cost of medical and surgical aid, or the direct grant of such aid, in all its ramifications, in kind.

The necessity of medical aid, as a part of a sickness-insurance system, would seem quite obvious. Nevertheless, it must be remembered that in at least two American compensation acts (Kansas and Washington) this feature is completely lacking, and perhaps the most amazing thing is that in Washington this most essential omission took place in connection with a state insurance plan. In one tentative American draft of a sickness-insurance bill which reached the writer, no provision was made for medical benefits. This is also rather frequently true of voluntary American sickness-insurance schemes, as operated by trade unions or establishment funds, while, on the other hand, in the large cities of the eastern states, many co-operative organizations (lodges, etc.) are found among foreign-born workmen which endeavor to grant cheap medical aid only, independently of money sickness benefits. It cannot, therefore, be stated too emphatically that only through a combination of both of these forms of relief can the social purposes of sickness insurance be accomplished.

Preventive effects of medical aid.—It is rapidly becoming recognized that the most important, though indirect, social purpose of insurance is its preventive effect. The recent sensational charges against fire insurance were largely based upon the assertion that the effects of its methods were contrary to prevention, and the defense pointed at the preventive effect of schedule rating. The broad movement for "safety first" resulting from compensation legislation is a matter of recent history, and the various compensation-insurance carriers vie with each other in extending measures

of prevention in order to establish for themselves the right to continued existence. Even in the old and well-established business of private life insurance, the movement to accomplish not only successful selection, but also prevention, is gaining strength and finds expression in the Life Extension Institute, in the nursing service, in periodic examinations of insured, in the recognition of social responsibility toward the rejected applicant, and so forth.

Perhaps in no branch of insurance is the road to prevention so clearly indicated as in sickness insurance through the granting of medical aid. So far as the curative effect of treatment of individual cases is concerned the same situation is found in accident compensation. But only in rare cases are working-men subject to repeated industrial accidents, and the effect of a successful treatment of one injury in preventing another is somewhat far-fetched. But in sickness insurance the connection between one attack of illness and another is direct and obvious. Every case of illness is, strictly speaking, a predisposing cause for subsequent illnesses. Even in case of those forms of sickness which are followed by immunity, a general debilitating effect cannot altogether be avoided. Naturally the prevention of the destructive effects of illness depends to a large extent upon treatment and care, and the organization of a proper system of medical aid for the masses is perhaps one of the greatest factors in the modern movement for life conservation. In fact, though in case of sickness of the bread-winner the obvious, immediate need may be for financial relief, it would be no exaggeration to say that, so far as final results are concerned, proper treatment and a rapid cure of the patient are matters of far greater moment.

It is scarcely necessary to state that in Germany, Great Britain, Denmark, in fact in all countries which have systems of sickness insurance worth the name, medical aid is an integral part of the system.[1] In this country, because of the appalling spread of nostra, cure fads, faith-treating, Christian Science, etc., some considerable opposition to an effective system of medical aid in connection with a public insurance system may be expected. But whatever the political necessities of various "local situations" may bring, the

[1] The total omission of medical aid in Ireland is a distressing exception.

expert draftsmen of legislative proposals should not be willing to assume any compromising attitude in this all-important matter.

Extent of medical aid.—While all national sickness-insurance systems are alike in making some provision for medical aid, there is great variety in the extent and methods of such service. It is well, therefore, to begin by enumerating the various headings into which the broad term of "medical aid" may be divided: (1) ordinary medical aid; (2) ordinary surgical aid; (3) obstetrical aid; (4) major surgical aid and treatment by specialists; (5) dental care; (6) drugs and ordinary surgical supplies; (7) special apparatus and appliances; (8) hospital care; (9) sanatoria; (10) convalescent homes and institutes.

The list will emphasize the complexity of the problem, which may not be obvious to the layman. The division may appear unnecessarily minute. The ten forms, or perhaps degrees, may be summarized in the following three groups: (A) medical treatment (1–5); (B) supplies (6, 7); (C) institutional care (8–10). When thus stated, the necessity for each group becomes obvious; drugs or other supplies may become necessary in all cases and, in some, effective results cannot be expected without institutional care. In the three countries selected as types, some provisions are found in regard to each of the three large groups of aids, but in each country the legislative situation is different.

The Danish system being optional, the law can establish only minimum requirements as a condition of recognition and of subsidy. All three forms of service are recognized in the law, but the extent to which aid must go cannot in the nature of things be specified. Nevertheless, it is significant that the recognized societies are *required* to furnish hospital treatment *when necessary*.

While the system is compulsory in Germany, the principle of local autonomy limits the law to minimum requirements only, and further extensions of the service are left to the individual funds. The minimum requirements are perhaps not very extensive; they include medical attendance, supply of medicines, eyeglasses, trusses, and other minor therapeutic appliances. This would seem to be grouped under the headings 1, 2 (possibly 4 with limitations), 6 and 7 (with limitations). In regard to institutional care, the

language of the law is not exacting, *permitting* the funds to substitute hospital treatment for ordinary medical care, although, as a matter of fact, the development of institutional treatment in Germany has been very extensive.

Finally, Great Britain is perhaps the only country which embodied in its sickness-insurance law a definite and almost uniform system of medical aid. This is consistent with the general principle of national uniformity in the British system. The general provisions of the act include general medical aid, ordinary drugs and supplies, such other appliances as may be included by administrative regulations, and the much-discussed "sanatorium benefits," to be granted only in cases of tuberculosis and such other diseases "as the local Government Board may appoint." Further extension of the medical benefits is permitted as optional benefits. The situation in Great Britian is perhaps the reverse of that in Germany, in that the actual conditions are very much inferior to those laid down as obligatory in the law. Since the German principle of reasonable local autonomy has been adopted as a necessary standard for American legislation, as against the English system of national uniformity, how far shall our legal requirements as to medical care go?

The writer's own choice is based upon a deep appreciation of the utmost importance of proper medical care, perhaps owing to a few years of active practice of the medical profession. Obviously, however, it is useless to put requirements upon the statute books, which society on a certain cultural level is utterly incapable of meeting. If a national sickness-insurance act were in contemplation, such an act could embody as a minimum requirement nothing which even a frontier community, such as Montana, or a backwoods community of the South could not comply with. But since sickness-insurance legislation, like compensation legislation, will most likely proceed within state lines, it would be decidedly wrong to establish no higher minimum requirements for New York or Massachusetts than would appear adaptable to Wyoming or Florida.

Limiting our discussion for a moment to the states of a higher cultural level, we may ask, What shall the minimum requirements

be, as expressed in the legislative act? Up-to-date homes for convalescents or Zander institutes may not be expected in every country and school district, and the development of such methods of cure may be left to the voluntary effects of the local sickness-insurance carriers. But outside of such extreme demands, it seems to me, nothing less than thoroughly adequate medical and surgical care, including supplies, apparatus, hospital and sanatorium treatment, is justified.

Of course this is a much broader program than the amount and degree provided in Great Britain either by the language of the law, or in actual practice, or in Germany by the general law (though not as actually applied), and yet this formula is the least that conforms with the ideal of the life-conservation movement of this country. Medical aid is not worth having unless it conforms to the proper standards of the medical science of the time. We may well discuss the extent of economic relief which society may grant to its disabled wards, but the first and absolute prerequisite is that it does all that can be done to cure them. To insist that less is sufficient for the workman, because he is a workman, is to destroy altogether the constructive character of the entire sickness-insurance idea, considered as part and parcel of the modern movement for scientific prevention of destitution. Wherever, therefore, social conditions at all permit it, all the ten forms of medical care enumerated above must be included in the minimum requirements of the law.

Ordinary medical aid.—The necessity for ordinary medical and surgical aid is, or should be, quite self-evident. In the entire criticism of the practice of the British national health insurance system made by the Committee of Enquiry of the Fabian Research Department (Sidney Webb, chairman; see Special Supplement to the *New Statesman*, March 14, 1914) nothing carries so much weight as the evidence that even the performance of ordinary operations is not always guaranteed to the insured workman. If medical care under a socially organized system of sickness insurance should degenerate to a rapid, careless prescription of drugs by hurried and overworked physicians, then the entire preventive effect of the system would be completely nullified. Nor is it necessary to argue that competent obstetrical aid is an absolute necessity. This

feature, however, will be dealt with at greater length presently in connection with the entire problem of maternity insurance.

In a "backwoods" frontier community the requirements of expert surgical aid for major operative work and of treatment by specialists may appear extravagant, but in the East and North Central states, at least, it may reasonably be included among compulsory requirements. It is preposterous to guarantee to the ill workman the diagnosis in case of appendicitis, or cancer of the stomach, but not the operation; it is preposterous to expect him in case of some special forms of disease, such as diseases of the nose, throat, or eye, or of the nervous system, to be satisfied with care by an incompetent "general practitioner," or family physician; for this would reduce the quality of care given even below that to be obtained from free dispensaries. In the majority of German cities this specialized medical service is being granted, and in progressive American communities it is equally possible. It is only because of an archaic and faulty organization of medical practice that the concepts of specialized expert medical service and expensive service have been merged into one in public opinion. The necessity of specialization in medicine has been recognized at the same time that facilities for such successful specialization have grown. The practical methods for securing the treatment of special diseases by special experts only, and at no exorbitant cost, can be brought about by proper organization, of which more will be said when the problem of organization of medical aid is reached.

Dental care.—The general principles announced above are equally applicable to the question of dental care. Here again some constructive steps will be necessary, as the situation in Europe is far from satisfactory.

In Denmark no requirement as to dental care is contained in the act, and there is no evidence that the recognized societies furnish it to any extent. The British act refers to dental aid as one of the permissible "additional" benefits. The new German act specifically refers to dentists, but the extent of dental care is not prescribed. Presumably, simple measures like extraction are considered an essential part of medical aid. The tendency among larger funds is to provide for extensive dental service and a few

funds even provide part of the cost of prosthetic dental work (artificial teeth, crowns, bridges, etc.).

The superior development of the science and practice of dentistry in the United States furnishes a basis for a more liberal and more satisfactory provision of dental aid. Scientific dentistry has long been recognized in this country as a necessity rather than a luxury. In establishing the minimum cost of a standard of living, the Massachusetts minimum-wage board included a small amount for dentistry. It is true that dental diseases are seldom sufficiently severe to interfere with earning capacity except for very short periods of time. But the harmful, though insidious results of dental defect upon the general state of health have already been recognized. "There is" says Professor Osler, perhaps one of the world's greatest physicians, "not one single thing more important to the public in the whole range of hygiene than the hygiene of the mouth. If I were asked to say whether more physical deterioration was produced by alcohol or defective teeth, I should unhesitatingly say defective teeth."

Many investigations have established the great prevalence of dental diseases among all ages and groups of the masses. Wage-workers, themselves, are also to some extent aware of these effects. The amount of money spent by the poor for dental work is rapidly increasing, but unfortunately it is seldom spent so as to produce the necessary results. Within recent years popular dentistry has been grossly commercialized through the development of so-called "dental parlors." In these the pressure is always for prosthetic dentistry because that is the most expensive and therefore the most profitable to the commercial dentist. The masses are never told that this is the least useful and most objectionable form of dental aid, nicknamed "septic" dentistry by some experts in the line. The cheaper and much more effective prophylactic work is disregarded. Within recent years, however, the hygienic importance of early dental aid has been so well recognized by scientific students that organization of regular dental departments in responsible hospitals is rapidly becoming the rule. The inclusion of systematic dental aid as a required branch of medical care is urged here, therefore, because of its general hygienic effects, and also because

it will prove economical in the end by substituting early and cheap satisfactory relief for delayed, expensive, and often harmful "gold teeth."

Medical and surgical supplies.—A difference of practice may also be observed in the furnishing of the material aids to medical care—drugs, supplies, etc. In the voluntary system of Denmark the furnishing even of drugs is optional, with very unsatisfactory results. According to the latest data, more than half the societies (57 per cent) entirely refused this service. Only 18 per cent paid for the entire cost; while the remaining 25 per cent contributed only a part of the cost. Thus the results of the voluntary system are seen to affect the quality of the service very seriously by leaving an economic motive for saving on necessary drugs and supplies. In both the British and German acts, the furnishing of drugs and ordinary supplies is compulsory. As to the more expensive surgical and medical appliances, the British act leaves the question of how far they shall be furnished to administrative regulations by the insurance commissioners. The German law, in accordance with its general methods of establishing minimum standards only, makes the supply of "eyeglasses, trusses, and other minor therapeutic appliances" compulsory upon the sickness funds. In actual practice many German funds go far beyond that, and provide artificial limbs, artificial eyes, etc. In Great Britain the situation is unfortunately just the reverse. The actual practice, as established by administrative regulations, is very inferior to the plain intent of the law, as neither trusses and elastic stockings, nor crutches, and not even eyeglasses or syringes, are furnished, not to speak of such "luxuries" as artificial limbs.

Such limitations are very undesirable and fully justify the severe criticisms made by the Fabian committee. "Medical care" is nothing but a delusion, unless the necessary mechanical appliances are available to carry into effect the advice given by physicians. Some appliances may be expensive, but it is just because they are expensive, and because they are required in rare cases only, that they can be furnished by the insurance method much more easily than by individual purchase. Moreover, as measured by the amount of relief granted, and even by the resti-

tution of earning capacity, these appliances, as trusses, elastic stockings, eyeglasses, or even artificial limbs, are the cheapest forms of surgical aid. A system of public sickness insurance is derelict in its duty if it fails to accomplish all possible results. A normal act has therefore the choice of only two methods: either to enumerate a very detailed, almost exhaustive list of permissible appliances to be furnished according to proper medical advice, or to use the broad formula of the Wisconsin compensation act, and to establish in plain terms the right to *all* necessary aids to treatment.

Institutional treatment.—The conditions outlined above may well apply (perhaps with the one exception of specialized medical and surgical aid) to all communities. In regard to the third group—namely, institutional treatment—the problem is somewhat more complex.

Hospital treatment is becoming more and more important in dealing with serious illness, partly for technical and partly for social reasons. There are diseases which in the very nature of things require constant medical attention. It is true that recently medical science has recognized certain disadvantages in hospital treatment, and has indicated conditions under which home treatment may be equally effective medically and more desirable for psychologic reasons. But this may be realized only under conditions which are quite utopian as applied to working-men's homes.

Ordinary hospital treatment is recognized as a necessity in almost all European sickness-insurance systems. The Danish law requires the recognized societies to furnish it whenever necessary and some arrangements to supply it are made by practically all societies. The legal requirement that hospital charges to the recognized societies must be only half the regular charges proved a large inducement. As general hospital facilities are good, there is seldom any necessity for special hospitals for the exclusive use of the societies. While the German act is not very exacting in its language, as a matter of fact there has been a very extensive development of hospital treatment in connection with the German system. Practically all important sickness funds furnish it, and in many of them from 10 to 15 per cent of the total budget is expended for this purpose.

The development of sanatoria and convalescent homes has been largely optional. Very little has been accomplished in Denmark; on the other hand, in Germany, the development of such institutions, largely owned by the sickness funds themselves, has been very rapid. Thus, e.g., the Leipzig fund has three convalescent homes and a special Zander institute for treatment of functional disorders by special exercises, Munich has two sanatoria, Hamburg two convalescent homes, etc. This is entirely independent of the special institutions established by the invalidity insurance institutes operating under the old-age and invalidity insurance laws, which furnish a good deal of medical aid to those insured. It is the invalidity institutes which have provided some 65 sanatoria for special treatment of tuberculosis with very important results.

The whole problem of institutional treatment in Great Britain is still in a very unsatisfactory condition. The so-called sanatorium benefit is limited to tuberculosis and such other diseases as the Local Government Board may designate, but as yet no others seem to have been so designated. The sanatorium benefit is therefore comparable to the tuberculosis treatment of the German invalidity insurance, or would be, if in reality it were not so much inferior to the standards of the law. The sanatorium benefit may be given in form of dispensary or even home treatment, and in actual practice often resolves itself only into supplementary allowances to the physician for medication in cases of tuberculosis, which should be a constituent part of the ordinary medical aid. The serious obstacle to the proper development of this benefit is the appalling insufficiency of hospital facilities in Great Britain; but this, it is hoped, will be gradually overcome through the special appropriations for construction of tuberculosis sanatoria. Nevertheless, even if the reality is very much below the standards established by the law, it has accomplished some good by attracting public attention to the lack of hospital facilities, and creating a constant, urgent demand from the insured for correction of this evil.

It is evident that in the regulation of institutional treatment, more than in any other branch of medical care, a certain latitude

may be allowed out of consideration to "local conditions." Each state may decide for itself how far institutional treatment may be made obligatory upon the sickness-insurance funds. If the state is territorially large, and conditions throughout are not uniform, the actual extent of institutional treatment may be left to the fund itself, or to administrative regulation.

Nevertheless simple acceptance of prevailing conditions as necessarily final would be out of harmony with the constructive character of this legislation. A modern community cannot claim any cultural standing if hospital facilities for treatment of grave illness are insufficient. Unless the geographical difficulties are very serious, or population very sparse, and means of transportation unsatisfactory, an earnest effort should be made, in conjunction with sickness-insurance legislation, to build up a sufficiency of hospital facilities. The same is true of special sanatoria for consumption, while the further refinements, such as special institutes and convalescent homes, may for the present be left to voluntary communal effort. It may appear that the joining together of these two issues is somewhat irrelevant, and that a state will, or will not, have sufficient hospital facilities, irrespective of all sickness-insurance legislation. But the obvious reply is that the insurance system creates a fund, out of which hospital treatment for its members may be paid (as explained presently), that this fund will be constituted largely through contributions from the insured themselves, and that they have an implied right to be furnished with not only purely formal "medical advice" but also effective medical aid. There are no difficulties, except financial ones, to the increase of hospital facilities, and the insurance system is designed for the very purpose of meeting such financial difficulties.

Conditions of medical aid.—Since insurance is a contractual obligation, some limitations are often inevitable, but comparatively little need be said concerning the limitations of medical benefits. In every insurance contract some time limits are necessary. In private insurance the policy period, and in collective insurance membership in the insurance organization carry the natural limits, while membership itself depends upon employment in an insured trade.

Of course all benefits of membership must extend beyond the period of active employment into the period of illness with payment of benefits. But such extension is also subject to a limit, so long as the line of demarkation between sickness insurance and invalidity insurance is accepted as already explained. Just where this line of demarkation should be placed may be discussed with better advantage in connection with the money benefits.

There may be a time limit at the beginning of illness as well, which under the term of "waiting period" has become a distinct feature of compensation in the United States. This, however, is obviously inapplicable to medical aid, where promptness is a matter of greatest importance. Universally, therefore, the right to medical aid begins with the beginning of illness.

Under the same term "waiting period" an entirely different time limit may be meant: namely, the time which must elapse after the beginning of insurance before the right to the benefits is free from all restrictions. Strictly speaking, it is a period of probation, during which the insured person is really not insured though he may pay the necessary dues. Such a provision may be necessary under a voluntary system for the purpose of eliminating persons who might insure because they know themselves to be sick. In the Danish voluntary system such a "waiting period" of six weeks is required. But while there may be some important reason for such a period of "suspended insurance" so far as the payment of money benefits is concerned, it appears altogether unnecessary in application to medical aid. The possible abuse of the medical-aid privilege is far less important than the danger of denying aid to anyone in real need of it.

A considerable amount of medical aid may be needed, moreover, in cases not requiring any discontinuance of work. In such cases any limitations upon the amount of medical aid to be furnished would be socially indefensible, since the hygienic effect of such aid would counterbalance any consideration of excessive cost.

Organization of medical aid.—It is impossible, in this brief outline of standards, to devote much space to consideration of administrative details. But although the problem of organization of medical aid is distinctly an administrative problem, an exception must be

made in its favor, in view of its tremendous importance for the successful operation of the entire scheme. In almost all systems of sickness insurance, medical aid is furnished in kind, instead of by money contributions to meet its cost, as is done in the American compensation practice. This is necessary for considerations of both economy and efficiency. The entire preventive effect of sickness insurance largely depends upon the successful organization of medical aid.

The most difficult problem during the period of organization of the system in Great Britain and the most scathing criticisms after its institution were all connected with the organization of medical aid. The medical profession in this country is more numerous, better organized, and on the whole wields a greater influence than the profession does in Great Britain. There can be no doubt that so soon as sickness insurance leaves the domain of pure theory, and enters the legislative stage, the medical profession will become very much alive to the situation, and will try to shape legislation to suit its own professional views and interests. It is necessary, therefore, to determine in advance what form of medical aid is desirable from a broad social point of view, and also what part of the ground it may be necessary to yield to the interest of the medical profession as well as to the established customs of the varied elements of the population of the United States.

In order to be able to discuss intelligently this rather specialized problem, it is necessary to indicate briefly the essential problems of medical practice, to which the majority of American students of economics and social science have as yet given very little thought.

The established form of administering medical aid in this country, so far as paid service is concerned, is through so-called "private practice." Medicine is one of the oldest liberal professions, and private practice for a fee is the recognized, time-honored method of performing the service in the liberal professions. As a matter of fact only a few professions have succeeded in preserving this system as a predominating one. While private practice for a fee is still the rule in medicine and law, elsewhere this has given way to the usual contract and stipulated monthly or weekly remuneration. This is largely true of the engineering

profession, the teaching profession, theology, most forms of scientific and social investigation, etc., although in each and every one "private practice" survives to a limited extent, especially in case of the leaders and experts, who may serve in a consulting capacity.

The forces behind this change are not difficult to discover. Private practice gives way as one large employer, either individual or corporate, takes the place of many petty ones. A definite wage contract is preferable because it is both economical and more efficient. There is a better utilization of time, resulting in a smaller cost per unit of service, though the worker's total earnings may increase. Besides, a regular wage contract permits of assignment to special duties, leading to division of labor and specialization such as is very difficult to accomplish under a system of private practice.

The American people is accustomed to private practice as the normal type so far as the paid practice of medicine is concerned. It has learned to look to institutional treatment by a staff, as a system adapted only to charitable medical aid. The natural consequence is to look to private practice as a more satisfactory, though more costly, form of medicine. Nevertheless, even in this country, the wage-workers of the larger cities have sufficiently demonstrated the economic feasibility of medical aid under some systematic arrangement between a body of prospective patients and the physician.

The first practical question that must confront the constructive social legislator in approaching this problem is this: Can medical aid, on the broad lines indicated above, be given without some change in the customary conditions of private practice? That is, are these conditions at all adapted to the needs and means of the working class?

An answer to this question may be found in the present status of medical aid to the workers. Because private practice is expensive, even though the scale of fees for physicians practicing among the poor is comparatively low, medical aid is not sought except as a last resort. There persists a harmful tendency to self-medication, a popularity of injurious nostra, or a plain neglect of chronic ailments. Medical aid among the poor is largely inefficient.

It is administered almost exclusively by so-called "general practitioners" or "family physicians"—Jacks-of-all-trades, whose persistence is out of all harmony with the recent phenomenal development of scientific medicine. There is perhaps a distance of a quarter of a century between the present status of medical science and that of medical practice among the poor. Conditions of private practice among the poor do not offer an inducement to careful examination, to study, or to the application of modern methods. There is no doubt that conditions of dispensary practice—at least in first-class public dispensaries—are very much superior because they offer expert advice of specialists and possess the necessary modern equipment. But dispensary practice is largely limited to ambulatory patients, placed on a basis of charitable relief, and therefore has serious drawbacks of its own kind.

It might be argued that the creation of a large fund for the treatment and relief of all workers could improve these conditions without necessarily disturbing the underlying basis of private practice. This is entirely conceivable. To some extent it is the condition prevailing in the practice of accident compensation, since most American acts impose upon the employer (or the insurance-carrier) the duty of paying for the necessary medical aid, instead of requiring that such aid be furnished in kind.

But there are very serious objections to such a system. The first consideration is that of economy. In compensation the cost is borne by the employer, who presumably is able to bear the high cost of medical aid. Some 20 to 25 per cent of the cost of accident compensation in this country is consumed in physicians' bills. Yet, though the injured workmen do not directly pay the bills, they suffer from their excessive scale, because the amount of medical and surgical aid to be given is entirely too closely limited in most states, mainly out of fear of the excessive charges of private physicians. In sickness insurance the workers themselves bear a large share of the burden, and strict economy is more urgent. Disorganized medical aid is uneconomical just because of this lack of organization. Excessive cost of the unit of service does not always spell excessive income of the practitioner because private practice is hopelessly tied up with loss of time for the majority

of the practitioners. The unsuccessful ones barely make a living, though charging from $1.00 to $2.00 for a few minutes of work. The successful ones must grow hurried and careless in their work, since their income is in adverse proportion to the time and care they are willing to give to the patient. Besides, the broad effect of prevention of ills is almost altogether lacking in private practice; medical control over those who are ill, or those who claim to be, is made very much more difficult; malingering is directly stimulated.

If some sort of organization therefore seems clearly indicated, the exact lines on which it must proceed are still subject to many fluctuations. Complete organization would presuppose a state of affairs in which all the medical work to be done for the members of a sickness fund would be done by physicians and surgeons (one or many, as the case may be) who are specially employed for the purpose and devote their entire time to it, as is the case with the internes in hospitals and in other institutions. That is not at all a revolutionary proposal. It exists in many industrial corporations, it is found on a national scale in the famous system of Russian village medicine, and often gives excellent results. It is in use in some German sickness-insurance funds and is advocated by many experts on sickness insurance and by a goodly proportion of administrative officers of sickness funds.

But this entire elimination of private practice among members of a sickness-insurance system has raised very strong objections from two sources—the medical profession and the insured themselves. The physicians are opposed to such complete organization because they fear that in it place will be found for only a limited portion of the profession—which seems to be a tacit admission that the medical profession is already overcrowded. It is true that the census indicates some 150,000 physicians in the United States or 1 physician to a population of some 600. Yet it is difficult to say whether this proportion is excessive. There are many idle physicians, but there are also many overworked ones, and many ill persons who do not receive adequate medical aid. If the average annual number of sick days per adult person is about 10, a population of 600 will give some 6,000 days of illness, or some 20 patients per every working day for each physician, perhaps as

many as one should be required to care for. But, in every civilized community the number of physicians required for the work of control, of investigations, of public health and hygiene is growing fast, so that the foregoing proportion is probably higher than will be found in actual practice. Moreover, no system of sickness insurance contemplates the inclusion of the entire population, and among the higher social strata private practice with its higher fees and greater income and leisure for the medical practitioner may still persist. Be it as it may, the interests of the physicians—an important, powerful, and intelligent element of our population—cannot be disregarded, especially as regards those who are already in practice. If the profession, however, be already overcrowded, a situation which would bring that fact to light and prevent excessive increase in the future is of itself not an undesirable one.

Another serious objection which is advanced by the medical profession is that complete organization of medical practice would lower the standard of medical income and would close the avenues for advance to the ambitious members of the class. This argument can be very readily disposed of. High medical incomes are very few and far between. They are found almost exclusively among the fortunate few who are ministering to the ills of the wealthy. In practice among the poor, large incomes can be achieved only through exhaustive overwork or by gross neglect of the interest of the patients. The difficulty is that the entire psychology of the medical man has been adjusted to a speculative hope of exceptional success, a factor wholly absent in most other liberal and scientific professions, and one which cannot but have a very detrimental effect upon the entire psychology of the profession and its attitude to social problems.

Freedom of choice of physicians.—A quite different line of defense of private practice is advanced by the general public, namely, the necessity of freedom of choice of physician because of the intimate relation existing between physician and patient and the necessity of complete faith in the selected healer as a prerequisite to successful treatment. That is a force to be reckoned with. A measure of social amelioration cannot be successful if

it runs directly opposite to the wishes and sentiments of the beneficiaries, no matter how ill grounded such sentiments may be. Nevertheless, in planning for large measures the effect of which will mainly manifest itself in long-range changes, it is proper not to accept these wishes and sentiments as final and conclusive. Of course the advantages of such freedom of choice are largely illusory. It does not exist in thousands of smaller communities where there is no choice. It is not expected in hospitals and dispensaries to which literally millions of workers and their families apply for medical aid. It is but seldom exercised in regard to selection of specialists when the suggestions of the family physicians are accepted. It is waived, so far as the individual members are concerned, in a large number of lodges, after the selection of the physician has been effected by a democratic vote.

Scientifically, the advantages of a free choice are open to criticism. They may have been great so long as the function of a physician was exercised largely by moral suasion. But scientific diagnosis, serotherapy, and skilful surgery do no depend for their success upon such whimsical considerations. In large industrial communities the poetic "country doctor," who took care of several generations, has long since given way to the modern commercialized practitioner. It is preposterous to imagine that the average working-man or woman, altogether ignorant of even the elements of physiology and hygiene, is able to pass intelligent judgment upon the professional accomplishment of his physicians. But because professional success depends much more upon the physician's reputation in the community than upon his professional standing among his colleagues, the free choice of physician is defended by the medical profession, representing as it does a valuable asset, comparable to the "good will" of commercial undertakings. The constructive legislator, therefore, need not be intimidated by the intrinsic value of the defense of free choice, but he must reckon with it, nevertheless, as a social force, which cannot be antagonized too strenuously, since the success of the whole plan of sickness insurance is involved.

The practical conclusion, therefore, seems to be that medical organization is to be aimed at so far as conditions will permit, but

that in deference to existing conditions some freedom of choice among physicians, wherever possible, must be provided for. But shall this freedom of choice be limited to the physicians who have entered into a contractual relation with the fund, or shall it be extended to the practitioners of medicine generally? European experience offers a variety of expedients. In Denmark, the law does not undertake to regulate the conditions of medical aid. In practice, all forms are found, from assignments of physicians to definite districts, to freedom of choice of any physician. Yet the last method is rare, and the prevailing method is either the designation of a district physician, or the right of choice between a limited number of physicians employed by the fund. In Germany, the law demands the freedom of choice between at least two physicians "if it does not add excessively to the cost," with the important limitation that all medical aid must be furnished by physicians under contract. Here, also, practice has created both types, while the question of comparative advantages of the physician employed outright and selection from a large list of physicians still remains one of the most mooted questions in the practice of German social insurance.

The question of local option in regard to organization of medical aid has been approached by the British Health Insurance act in an entirely different spirit. The national act prescribes a system which is practically uniform throughout the land. The system was decided upon as a compromise after a stormy conflict with the medical profession, and bears strong evidence of a desire to placate it, to protect its interests at times to even a greater extent than the interests of the millions of insured workmen. The resulting system of "medical panels" (or registered lists of physicians) grants the right to practice among the insured for a stipulated annual amount to each reputable physician.

The right to practice among a certain class of population is therefore recognized as a vested right of the profession and of all its members. Sufficient evidence has already accumulated that the system does not work well in many particulars. It has prevented the sickness-insurance funds from making any selection between physicians, or from hiring and training inexpensive specialists.

It has left the entire choice in the hands of the individual workman, and preserved the economic dependence of the physician upon the good will of his clients. It has placed no limits upon the number of insured patients a physician may have, and has therefore stimulated low-grade competition among physicians for the capture of the largest possible number of contract clients. It has limited the insured practically to one physician, and made treatment by specialists unavailable. In short, it has increased largely the amount of medical advice given without at all improving its quality. Cases are reported in the Fabian report of physicians who have as many as 9,000 insured on their lists and who are forced to hire one or more assistants in order to give them even the most superficial treatment.

There is very important warning in the English conditions of what the worst abuses are, which must be carefully avoided. The writer, who is somewhat familiar with the conditions of medical education and the legal requirements for practice in this country, can safely say that variations between the highest and lowest standards are such that neither a medical diploma nor a state license is a sufficient guaranty of efficiency. There is absolutely no reason why a sickness-insurance institution, with the means at its disposal, should renounce the right to intelligent selection of its medical practitioners according to standards established by competent authorities. There is no reason why it should permit the commercial spirit of some practitioners to interfere with the efficiency of the campaign of health preservation which in the long run will be the most important aspect of the insurance system.

It may well be that under the pressure of the medical profession some "panel system" will be forced upon American sickness insurance. In that case the interests of the insured will have to be protected by definite requirements which will limit the number of permissible clients for each physician, and which will establish a rigid system of control with right to suspend from the panel.[1]

Organization of drug supply.—In the organization of the distribution of medical and surgical supplies and other apparatus,

[1] The method and amount of remuneration of the physicians is one of the most difficult problems in organization of medical aid. It is impossible to go into this

parallel problems may arise, but they appear to be very much less complicated. With the exception of drugs to be specially compounded, we are dealing here with well-standardized articles of commerce which can readily be bought in the open markets. The problem is analogous to that of the consumers' co-operative movement, whose very soul is wholesale purchasing and elimination of the middleman's profits. There is a very potent argument, therefore, for direct distribution of such supplies, at least by the larger sickness-insurance funds. The compounding of prescriptions, however, has become a recognized profession and as such it succeeds in wielding a definite social influence. From this there has resulted a curious pressure for freedom of choice of druggists, as if drugs, like medical advice, depended for their efficacy upon personal confidence of the consumer.

The one serious difficulty about direct assumption of the drug and supply business by the sickness-insurance carrier is the local character of the druggist's trade and the necessity for emergency service, which in large cities may make central distributing stations somewhat inconvenient. In Germany the peculiar laws in regard

problem at great detail here. *Medical Benefit in Germany and Denmark*, by I. G. Gibbon, contains a very careful discussion of this problem.

A great many different plans are operative in Europe. The simplest method is that of exclusive employment at a stipulated annual salary. At the other extreme is a scale of definite fees for visits, operations, and all other forms of medical service. The British plan represents a sort of crude insurance contract between physician and insured, since the former agrees to furnish all medical aid throughout an entire year for a small consideration. It would seem to be very much wiser if this function of insurance were lodged in a fund rather than in an individual physician whose remuneration, unless on a salary basis, were better adjusted in some proportion to the service rendered. Yet since the measure of the necessary service remains largely with the physician, a fee schedule, no matter how moderate, offers a constant temptation to excessive visits and bills. To counteract this tendency different schemes have been tried out in different funds. In Leipzig, e.g., a definite per capita charge is assigned to the entire body of physicians in a panel, to be distributed among them in proportion to the work done, which creates among the physicians themselves a controlling force to prevent anyone from claiming an excessive share. The whole problem may be said to be still in the experimental stage, and there is no necessity to embody iron-clad rules into the law, or to make them uniform for the entire state. So long as the central authority is given sufficient power to control the situation, time may be depended upon to bring out the best methods adopted to any community. The aim to be emphasized in the law is the quality of the service, rather than the details of remuneration.

to the licensing of druggists and drug-stores have strengthened their position to such an extent that the new act of 1911 practically guarantees them their vested interests in the business, with freedom of choice, and the funds may make contracts only for the limitation of charges. In Great Britain the consideration for the economic interests of the pharmaceutical profession went even farther, so that druggists' panels were established by the insurance commissioners practically on their own initiative. The complicated English arrangements may be justified by the fact that the societies are not organized in territorial limits, and their territories overlap, but where geographically limited funds prevail, the methods of drug distribution can be materially simplified. The sickness-insurance act may well require all large funds, with over a certain membership, to establish a direct supply of all therapeutic and surgical materials, with the exception of emergency prescriptions. It must, at least, not contain any provision which will prevent the development of such co-operative initiative. Through such economical administration, all arguments against the supply of rare and expensive drugs or apparatus may be answered.

Administration of institutional treatment.—So far as institutional treatment is concerned, definite rules in the law would appear premature. Undoubtedly the goal to strive for is the upbuilding of special hospitals, sanatoria, and similar institutions by the sickness funds. All this, however, will require accumulation of both the necessary funds and experience. Contractual agreements—also under the control of the insurance commission—will be the predominating method in the beginning. The appearance of a large body of paying hospital patients will stimulate the development of both private and public institutions. A sufficient period of time for the necessary transitional stage must be allowed, but eventually a certain number of beds in proportion to the number of insured must be demanded by the law. In combination with private benevolence and public health service the growth of hospital facilities must be developed until institutional treatment for all cases requiring it will become a matter of course.

There remains one very large problem in connection with the granting of medical aid, the discussion of which was intention-

ally withheld until some light should have been thrown upon the methods of organization and administration. The question is: Shall medical treatment be extended to the immediate dependents of the insured? At first, such an extension may be considered as altogether unwarranted. Sickness insurance deals with the disabled wage-earner. The entire philosophy of social insurance is based upon the causal connection between employment and disability on one hand, and between disability and unemployment on the other. The inclusion of insurance of others, even though they be members of the family, will be classed as a gratuitous application of socialist policy, and as such will call forth serious objections. Already this tendency has been disclosed in many private conferences concerning standards of sickness insurance.

Nevertheless, a strong inclination to include dependents is observable in all compulsory sickness-insurance systems. The German insurance code grants this among the many permissible extensions of the sphere of activity of the sickness funds, and the majority of the larger funds have done so, as, for example, in Leipzig, Dresden, Frankfort, Bremen, Hannover, Düsseldorf, Strassburg, Cologne, Essen, Mainz, Kiel, etc. Less common is a similar extension of the drugs and supplies benefit, but that, too, is found in many cities such as Leipzig, Dresden, Hannover, Mainz, and Kiel, while in Cologne, Essen, and some other cities half of their cost is met by the fund. In Denmark, though the system is optional, medical and hospital treatment to dependent children under fifteen years of age is one of the required benefits of the recognized societies. In the British act "medical treatment and attendance for any person dependent upon the labor of a member" is the first of the additional benefits, which may be instituted by any approved society which shows a disposable surplus after valuation. As yet this British provision is only a dead letter. The entire legislation as to additional benefits in the British act is highly unsatisfactory because it is made dependable upon a surplus from an iron-clad rate of contributions, so that no stimulus is offered to the insured to extend the system.

The demands of life evidently appear stronger than any theoretical constructions. A purely formal connection between the

insurance of the wage-worker and that of the members of his family may be lacking, but the social advantages of utilizing the established medical organization for the benefit of the entire working population are so great that any logical inconsistency may be calmly disregarded. The drawbacks of the present disorganized system of providing the poorer classes with medical aid are so palpable that it would be criminal to leave it undisturbed in the case of the wife and children of the breadwinner, in face of a system established presumably for his benefit. The entire purpose of this system is to eliminate any economic obstacle to the work of preservation of life and health, and surely the life and health of the wives and of the coming generation are of social value at least equal to the life and health of the laborers. With from 250,000 to 300,000 children dying annually in this country under the age of one, another 100,000 before five, and perhaps some 90,000 in ages from five to nineteen, the tremendous value of any improvement in preventive as well as curative medicine can hardly be exaggerated. That the working-man's family needs such aid no less than he it seems unnecessary to argue. And while the families of the insured may not need it more than the rest of the population, the fact that a comprehensive system must be organized for the head of the family is a sufficient social argument for extending the benefits to such persons at least as naturally and easily fall into the same group.

Perhaps the most obstinate objection to such extension may come from the medical profession, because this measure would represent a further, and for most of them a final, encroachment upon the domain of private practice. The state will have to face this issue squarely and to decide whether the conditions of practice of medicine should be adjusted to the needs of the people's health or whether these should yield to considerations of the economic interests of the medical trade.

Money benefits.—The conditions of the money benefit next require our attention.

Time limits: At the beginning of illness the question of the waiting period requires a definite decision. With the natural tendency to draw upon compensation experience in shaping sickness-

insurance standards, the question may become more acute than it ever did in Europe. To prevent administrative difficulties out of proportion to the economic loss of very brief periods of illness, and also to prevent a certain form of malingering, due to occasional debauch, a brief waiting period is advisable, during which money benefits (but not medical aid) may be denied. In Germany the law establishes a 3 days' period, though the local funds may shorten or remove it altogether. The period is also placed at 3 days in Great Britain, while in Denmark the voluntary funds are permitted (but not required) to have a waiting period up to 7 days. Unfortunately, in American compensation acts a longer waiting period (7 days in a few acts and 14 days in most) has become the rule. A similar tendency in sickness-insurance acts is certain to appear. It should be energetically contested.

The majority of cases of illness would fall within so long a period, and denial of benefits for all such cases would go far to discredit the entire system in the eyes of the workers.[1] Moreover, there is this distinction between accidents and sickness, that repeated injuries to the same individual are exceptional while repeated attacks of short periods of illness are not at all rare. Numerous recent wage investigations have established beyond any doubt that the omission of even one pay envelope may be a serious matter to thousands of workers, and an interval of 3 weeks between one pay day and another may often spell ruin to a family or call for charitable assistance. The watch word of social insurance should be "not a week without a pay envelope." A 3 days' waiting period is all that the entire experience of sickness insurance justifies.

Under a voluntary system the requirement of a certain period of insurance before the right to benefits is acquired may be advisable as a method of protecting the funds against unfavorable selection of risks. In Denmark, the determination of such a time limit is left to the various funds. Under a compulsory system such a waiting time is neither actuarially necessary nor socially just, since membership necessarily follows upon employment, and the average degree of health of persons actually employed cannot

[1] According to the experience of the Leipzig sick fund in 1912, 47.4 per cent of all cases lasted less than 2 weeks, after excluding cases under 3 days.

be influenced by any one individual's act. Nevertheless, the British act provides that no sickness benefits can be paid until the expiration of 26 weeks of paid-up insurance. It will be remembered that the actual payments of benefits did not begin until 6 months after the collection of contributions began, and in this way a substantial working capital was accumulated. As a temporary, fiscal measure, this may have been justified, though some doubt may be entertained whether the advantages derived proved a sufficient compensation for the amount of popular irritation created. The preservation of the same rule seems much less justified. However, since membership is compulsory and only one waiting period during the entire life of the insured is required, the regulation will affect only very young persons, and the amount of distress caused by this provision is probably small.

Finally, the German law specially prohibits any provision for a waiting period of this character, though in case of voluntary members a period not to exceed 6 weeks is permitted. Here again the German precedent is the one that should be followed.

How long should sick benefits be payable? The somewhat artificial but necessary line of demarkation between sickness and invalidity insurance has already been indicated. Just at what point the line is to be drawn must be decided upon somewhat arbitrarily. In Denmark, recognized funds are required to grant sick benefits for at least 13 weeks within one year. No maximum is prescribed by the law. In actual practice, some 60 per cent have retained the required minimum, about 25 per cent have increased it to various periods under 26 weeks, and the remaining 15 per cent have made it just 26 weeks. Practically no funds (with one or two exceptions) have gone beyond this limit.

In Germany, the original minimum period was 13 weeks, but was raised by the act of 1903 to 26 weeks. The local funds have the right to increase this period to 52 weeks, and may, in addition, provide for treatment of convalescents for another year. The German experience indicates that with a healthy democratic organization of sickness funds, voluntary extension of the minimum limit is not at all rare, but nevertheless the legal requirement determines the predominating type. In 1885, 80 per cent of the

funds kept to the minimum limit, and by 1903 about 75 per cent, several thousand funds increasing the time to longer periods up to 26 weeks. Since the raising of the legal requirement, less than 1,000 funds pay for from 26 to 52 weeks, these being largely establishment funds.

In Great Britain the line of demarkation between "sickness" and "disablement" (invalidity) benefits is drawn at the conclusion of 26 weeks.

There is no mysterious significance attached to the half-year period. But the only logical basis for determining the proper limit is the separation of cases of illness from those of chronic invalidity. A 13 weeks' period, according to available data, would leave some $3\frac{1}{2}$ per cent of the cases without aid perhaps at the time when such aid is most important. The number of cases extending beyond 26 weeks is only 6 per 1,000, and includes little besides cases of chronic invalidity.

On the other hand, the extension of time from 13 to 26 weeks can be granted at a comparatively slight cost. An analysis of statistics of the Leipzig fund (perhaps the best available and covering almost 90,000 cases of illness per annum) seems to indicate that the additional number of sick days which become compensatable because of an extension from 13 to 26 weeks constitutes only a little over 5 per cent of the total. Protracted illness may require a higher expenditure for expert medical aid, hospitals, convalescent homes, etc. In any case the additional loading must represent very much less than 10 per cent.

Amount of benefits: Until the advent of the British national health-insurance system, benefits computed in proportion to wages were practically the uniform practice of compulsory systems. The British act was the first to introduce a uniform scale of benefits for all. The practice of voluntary sickness-insurance organizations tends more toward uniform scales. It does not help much to point out that in the British system the contributions are uniform and therefore the benefits are uniform. That the same principle should govern both contributions and benefits must be conceded at once. But which principle should it be?

A uniform scale has certain advantages of simplicity, but very few other advantages. The wage-workers do not all live according to the same standard, and presumably there is some proportion between earnings and needs. It is true that in case of workingmen of very low earning power a benefit based upon a fraction of wages may be too small even for the essential demands, but provisions for a minimum to meet this situation have already become familiar to American legislatures. On the other hand, a flat uniform scale of benefits would either be too high for large groups of wage-workers and offer an inducement to malingery, or too low to be a measure of substantial relief to the better-paid workers. Especially are the arguments against one uniform scale strong in the United States. The extent of wage variations is probably very much greater in this country than in Europe, where fairly uniform conditions prevail. Within one state and even one city, common wage variations may be between $4.00 and $40.00 a week. Under such circumstances the problem of establishing one uniform and fair scale of benefit is a difficult one.

Judging from the experience of our compensation legislation, the actual scale of benefits may prove the gravest point of contention when legislative work seriously begins. Comparisons of what is being done in Europe may be offset by a natural tendency to follow standards already established in regard to accident compensation, since essentially the problems are identical so far as the needs of the family are concerned.

In European voluntary systems the benefits, as a rule, are entirely too low. An insurance system requires a careful balancing of income and outgo, of financial resources, and benefits payable. When required to carry the entire burden or when, as in Denmark, receiving only a small subsidy, the insured workman is unable to provide the cost of liberal benefits. In Denmark the actual amount is left to the discretion of the fund, with a minimum limit of 40 öre (11 cents) per day, and a maximum of two-thirds of the wages. As a matter of fact over 70 per cent were granting only 40–60 öre (11–16 cents) and only 12 per cent 1 krone (26.8 cents) or a little over. This sufficiently measures the limited efficiency of voluntary systems. The British scale is pretty well known (10*s.* for

men and 7*s.* 6*d.* for women, per week, with somewhat reduced rates for certain groups). In view of the actuarial rigidity of the British law, there are various other reductions to be made in all sorts of conditions which may influence the actuarial solvency of the funds, for, since the scale of contributions is rigid, adjustment, according to the law, must eventually be made through reduction in the benefit scale. Even if the actuarial basis of the system prove accurate on the average, it is inevitable that shortages will be discovered, and benefits reduced in many societies. This aspect of the situation will require a separate discussion in due place.

Where benefits are adjusted in proportion to wages, the usual amount is one-half of the wages, as in Germany, though not the actual wage of the sick, but an average or basic wage group is meant. Different basic wages for groups of insured of the same fund may be provided but the basic wage must not exceed 5 marks ($1.19) per diem. The maximum normal sick benefit therefore is 60 cents per diem, or $3.60 a week.

There is a curious tradition that in matters of social legislation we need not go above the minimum which European experience indicates. It is well known what pernicious influence the highly unsatisfactory British compensation act has exercised upon American legislation. The minimum German scale of 50 per cent should not, however, be accepted as the final word of Europe. Both Austria and Norway have made it 60 per cent, and in Germany permission is given by the law to increase the benefit up to 75 per cent. Some 10 per cent of the German funds, representing a very much larger proportion of the membership, have increased it to $66\frac{2}{3}$ per cent, and perhaps some 2 per cent even to a larger amount up to the legally permissible limit. There is, therefore, a strong feeling that 50 per cent is insufficient, and that the rate of sick benefits should be raised to the level of accident compensation. In the brief experience of American compensation enough evidence has already accumulated to prove that 50 per cent is insufficient to prevent poverty and an appeal to charitable relief, and that the normal scale should be placed at two-thirds as for industrial injuries, with a sufficiently high minimum and a reasonable maximum.

Maternity benefits.—Maternity insurance has recently been rapidly acquiring the dignity of an independent branch of social insurance. The Italian method of handling its problem through an independent system and institution has already been described in American literature. However, Italy has as yet no general compulsory sickness-insurance system. In other countries, maternity benefits are granted, if at all, in connection with sickness insurance. The relationship is quite obvious. The question whether childbearing, being a physiological process, should be properly classified with a sickness is a somewhat academic one. It requires medical aid. It produces temporary disability. That is sufficient to put it into the category of emergencies that a sickness-insurance system should deal with.

The function of maternity insurance may be analyzed under the following four headings, corresponding to the four causes of economic loss, connected with childbirth: (*a*) extraordinary expenditures for medical aid and supplies connected with childbirth; (*b*) the period of enforced idleness and the consequent loss of wages; (*c*) the necessary period of rest before childbirth, to preserve the health of the mother; and (*d*) the equally necessary period of rest after childbirth, for the purpose of both strengthening the mother and improving the chances of the child.

It appears, then, that maternity benefits have several distinct features, because the prophylactic factor is of greater importance and because the interests of the future generation are also directly concerned. Again there are three distinct aspects of the problem: (1) that of the married woman worker who combines the duty of a wage-earner with those of a housewife, or at least a wife, and is in most cases only partially dependent upon her earnings; (2) that of the unmarried wage-earning mother; (3) that of the wage-earner's wife who is "not gainfully employed" in the sense of not bringing any money revenue into the family treasury.

The distinction between the first and second aspects is largely a moral one, that between the first two and the third primarily an economic one. The moral problem involved should be easily disposed of. Motherhood out of wedlock is not as frequent here as it is in Europe, but so long as it exists the economic consequences

must be provided for. Social insurance has no official point of view on matters of sexual morality. From any point of view, the unmarried mother's health and her child's life must be taken care of. The economic need in her case is greatest. The only fair way of handling this problem is by entirely omitting in the act any reference to distinctions between legitimate and illegitimate births.

As between the employed, self-supporting woman and the dependent wife of a wage-worker, there are material differences. In most cases of the latter type there are no serious economic losses because of enforced idleness, except possibly the cost of hiring some help during a short period, when neighborly help is lacking, and therefore only the need for medical aid and supplies is involved.

There is a considerable variety in European practice. In fact, altogether fourteen systems of maternity insurance may at present be recognized, and ten of them are in connection with compulsory sickness-insurance systems (Germany, Austria, Hungary, Great Britain, Russia, Norway, Bosnia-Herzegovina, Servia, Roumania, Luxemburg). Italy has an independent system of compulsory maternity insurance, in Switzerland maternity insurance is a feature of the comprehensive but voluntary sickness-insurance system, and finally France and Australia have recently taken a new step in "social insurance" by providing non-contributing state pensions to lying-in women.

So far as our three selected types of legislation are concerned, very little has been accomplished in the voluntary system of Denmark. Lying-in benefits are not required by law, and as a rule are not given by the recognized societies beyond the medical aid necessary in cases of unusual complications. Attendance by physicians at childbirth is not common in European countries. A few societies provide insured women with the service of a midwife.

In Germany a substantial lying-in benefit, amounting to a sickness benefit for 8 weeks, is required by law for all insured women, no distinction being made between married and unmarried mothers. With the consent of the lying-in woman, medical attendance, services of midwife, or nurse, or hospital care, may be substituted for the entire maternity benefit, or parts of it. Special

pregnancy benefits, in case of incapacity up to 6 weeks, are among the optional benefits allowed by the sick fund, as also the extension of benefits to the wives of insured persons.

The maternity benefits of the British law have occasionally been referred to as the most liberal in Europe, but that is hardly correct. The basic maternity benefit is a flat amount of 30 shillings but this is payable both to the insured women and to the wives of insured men. However, in Hungary, Servia, Roumania, and Norway as well, maternity benefits to wives of insured persons are compulsory. In addition to the 30 shillings, insured women are entitled also to the regular sickness benefit during confinement. The 30-shilling provision is entirely free from any moral strings; all wives (or widows in case of posthumous children) of insured persons, and all insured women are entitled to it. Curiously enough, however, the additional sickness benefit just referred to is payable only if the "insured woman" is married. Some discrimination against the unmarried mother was after all dragged in to satisfy Anglo-Saxon moral standards.

Neither Germany nor Great Britain thus furnishes, at least in their laws (German practice being on the whole very much better than the minimum requirements of the law), the best that Europe can show in the development of this movement. Neither in Great Britain nor in Germany is proper medical, or rather obstetrical, aid required. Indeed, the British act specifically states that "medical benefit shall not include any right to medical treatment or attendance in respect of a confinement."

As a matter of fact, that is probably the main purpose to which the money benefit is applied. But is not this purpose sufficiently important to be achieved directly? Under the present system two results are often observed in England: the physician's fees have increased, and instead of a guinea, all the 30 shillings is charged frequently; or the woman in her ignorance may be tempted to save on medical aid, or on foods necessary to her, for the purpose of utilizing the ready cash for other purposes. Neither of the two results is socially desirable. Proper attendance at childbirth is a matter of primary importance to preserve the life and health of both mother and child. So long as the very existence of a sickness-

insurance system presupposes some efficient and economic organization of medical aid, why, in this branch of medical service, shall all the faults of private bargaining be left undisturbed? A maternity benefit should not accrue mainly to the benefit of the medical profession. Nothing can be so readily estimated as the approximate number of births, and nothing can, therefore, be so easily provided for in advance. In Austria, in Hungary, in Russia, in fact in almost all the compulsory systems enumerated above, such medical aid is required. It should not be forgotten that annually in the United States some 10,000 women lose their lives from childbirth, and that the number of those whose health is impaired because of unskilled aid is very much larger.

It seems scarcely necessary to argue that medical aid is needed for the wage-worker's wife, as well as for the woman who is a wage-worker herself. The problems which arise in England, as to whether the 30 shillings should be paid to the insured husband or his child-bearing wife, whether in a case of a dissipated husband the proper use will always be made of the 30 shillings, etc., could be easily avoided, if 30 shillings worth of efficient medical service and necessary supplies were furnished instead of money. For the woman who is self-supporting, the additional money benefit, no matter how designated, is equally necessary. "The twilight sleep" is still in its experimental stages, and even for the thoroughly healthy woman, child-bearing means enforced incapacity to earn a living for some weeks at least.

As to how long this benefit should be paid, laws again differ. The Italian law of 1911 establishing compulsory maternity benefit resulted from a labor law prohibiting employment of women within four weeks after childbirth. Of 12 countries granting maternity benefits, the required period is 4 weeks in six, 6 weeks in five, 8 weeks in two (Germany and France). Somewhere between 4 and 8 weeks must, therefore, be the minimum period of enforced rest after childbirth.

Under normal conditions, 6 or even 4 weeks after birth should be sufficient as far as the mother's health is concerned. But while a good many prospective mothers may retain their perfect health until the last day before birth, as a rule their earning capacity

stops some time earlier, nor is strenuous effort during the last few weeks quite safe to either the mother or the child. The German law permits at least 2 weeks' benefit before childbirth, the Russian act 2, and the French 4 weeks. These periods are included in the total period indicated above, but in several countries the law permits optional extension of benefits to pregnant women for longer periods.

Finally, the interest of the child would require an extension of time after the necessary period of recuperation for the mother. During this period breast feeding may be kept up, and some care given at the time when it is most important. In Germany, such extension up to 6 weeks is permitted. Altogether the liberal and prosperous fund may grant aid for 14 weeks to the wage-working mother.

To underscore the importance of these measures for purposes of health conservation, some figures of our mortality statistics may again be quoted. Some 60,000 children in the United States die annually from diseases of early infancy, half from premature birth, and half from "congenital debility" which in many cases could be overcome by proper care. Some 18,000 per annum in addition die from inanition, debility, and marasmus, practically all preventable conditions. And while it would be idle to claim that in all or in the majority of the cases the lack of mother's care is the cause, yet recent investigations by the United States Children's Bureau leave no doubt as to the importance of its lack as a contributing cause. Of course the data prove that undiscriminating distribution of benefits alone will not solve the question of infant mortality, as the Webbs have so significantly pointed out. For this reason assistance in kind, by medical aid, by visiting nursing, etc., is of even greater importance. But it is statistically established that three months of breast feeding have a decided preventive effect upon the extent of child mortality.

The practical conclusion, therefore, is: that maternity insurance should be made an essential part of sickness insurance, and that it should include: (*a*) sufficient medical aid, (*b*) at least a 2 weeks' period of rest before childbirth, (*c*) from 4 to 6 weeks' benefit after childbirth for the sake of the mother, (*d*) an equal period for the

sake of the child, (*e*) optional extension of these benefits by sickness-insurance funds which possess the necessary means.[1]

Funeral benefits.—There is no necessary logical connection between sickness insurance and funeral benefits, but the historical connection is very close. Compulsory insurance grew out of voluntary insurance, as practiced by mutual-aid societies, and help in funerals, both in kind and in money, was the earliest form of mutual aid. In many mutual-aid societies funeral benefits are given, but special funeral-aid societies are quite common in most European countries and in the United States.

This is true of Denmark, where sick-benefit societies do not grant funeral benefits. These are usually provided by formally independent burial clubs, but these are connected with, and under the same management as, sick-benefit societies. The separation is largely the result of the requirements of the law. The reason for such enforced separation is found in the possible actuarial dangers of an increasing death-rate among those voluntarily insured. Technically, funeral insurance approaches life insurance (since payments depend upon the contingency of death), and unless rates are scientifically built upon a mortality table, the difficulties of assessment in life insurance may arise. The state has established a reinsurance fund for these burial clubs, and the permitted amount of insurance is light—150 kronen (about $40.00) while as a matter of fact about 85 per cent of them grant funeral benefits of only 100 kronen ($27.00) or less. The British health insurance makes no provision at all for funeral benefits, for the same reason that may

[1] Lest this be considered a utopian program, it may be stated here that, notwithstanding all the financial pressure of the war, Germany by a decree of December 3, 1914, has voted 2,000,000 marks a month for the purpose of providing for the wives of men at the front the following benefits at childbirth: (1) 25 marks to meet the cost of childbirth; (2) 1 mark per diem (including Sundays and holidays) for 8 weeks, of which at least 6 must be after childbirth; (3) 10 marks for additional nursing and medical aid, if necessary; (4) in case of a breast-feeding mother, ½ mark per diem for 12 weeks, making a total benefit period of 20 weeks, and a total maximum cost of 133 marks, or $31.65.

In explanation of these measures the decree states that "the enormous sacrifice of human life which war demands make it the imperative duty of the state to take proper care for the preservation and strengthening of the coming generation at the very moment of entrance into this world."

have a decisive influence in this country, i.e., the popularity of so-called industrial life insurance, which furnishes little besides funeral benefits but has succeeded in reaching practically the entire wage-working population, and the definite objections raised by the industrial life-insurance companies against the inclusion of funeral benefits.[1]

In Germany, on the other hand, funeral benefits on the death of insured persons are compulsory. The normal amount is small, 20 times the basic daily wage, and thus limited to 100 marks as a maximum. Voluntarily, the funds may increase it to 40 times the daily wage (maximum 200 marks), or establish a minimum of 50 marks ($12.00). In addition, funeral benefits at the death of members of families are optional. In case of the death of wife or husband, they must not exceed two-thirds, and in case of children, one-half, of the normal amount. Funeral benefits of an equally modest amount are also granted by all other compulsory sickness-insurance systems, except that of Great Britain. What shall the attitude toward funeral benefits be in drafting American sickness-insurance acts?

It may be admitted that there is no such urgency about this form of benefit as there undoubtedly is about the other main branches of activity outlined above. Perhaps 80 per cent of the wage-workers, and a goodly proportion of the members of their families, are already protected by this, the least important, form of working-men's insurance. The preservation of a high standard of funerals, moreover, does not constitute the aim of social insurance. Besides, not to mince matters, the effort to introduce funeral benefits into a compulsory sickness-insurance system will undoubtedly create a very strong opposition from industrial life-insurance interests to the entire system proposed. It may be good politics, as it was in Great Britain, to yield without a fight—and keep these benefits out. But do these considerations entirely settle the matter? It would be out of place in this study to go into a detailed discussion of industrial life insurance as such.[2]

[1] See *New Statesman*, March 13, 1915, Special Supplement, p. 30.

[2] The writer has already done so in his work on *Social Insurance*, chap. xxv, "Life Insurance for Workmen," especially pp. 417–21.

But whether the high cost of life insurance to wage-workers can be reduced through a better system or not, it is evidently undesirable that a system which costs the American working-men some $200,000,000 per annum should result in no larger gain than an extravagant funeral. Even if industrial life insurance should remain as it is, anything that would prevent the established extravagance in funerals, and preserve the benefits of industrial life insurance for a purpose commensurate with its cost, would appear desirable. Extravagance at funerals among the poor has grown to be a serious economic problem, and as yet all efforts to overcome it have been unsuccessful. The assumption of this burden by the sickness-benefit fund would establish one fairly uniform standard, the acceptance of which would not mean loss of social caste, and finally, through democratic co-operative effort, it could cut down by probably more than half the altogether useless waste from overcharge and extortion of undertakers and cemetery-owners.

Compensation acts in various states have already established a standard of $100.00 for funerals. If all the burials among the workers of a large city were handled by their own organization, and in their own cemetery, the cost could probably be reduced to $50.00. And insurance for a burial benefit of that amount, with an average death-rate from 16 to 20 per 1,000, should cost from 80 cents to $1.00 per capita, per annum—about 2 cents a week.

The four main branches of effective service which a sickness-insurance system should furnish—medical care, sick benefits, maternity benefits, funeral benefits—have been outlined in the pages above. Throughout the discussion, it is hoped, a spirit of moderation in demands has been preserved, but the main conditions stated which must be created in order to realize the objects of modern sickness insurance. Though the system is compulsory, it should not be understood to place any limits upon the spirit of mutual aid and co-operation to which the organization of local sickness-benefit funds should prove a valuable stimulus. As in Germany, so in this country, voluntary extension of benefits may be expected. Of course, all such extensions should take place

under proper control, so as not to result in financial embarrassment, nor in encouragement of malingering. But in the early drafts of the laws, which must deal with the difficulties of organization, detailed provisions for such optional benefits are scarcely necessary. In fact, they may be even objectionable in that they would give (as do the additional benefits in the British National Health act) an appearance that some very desirable things are being accomplished, when as a matter of fact for some years to come all these additional benefits are destined to remain dead letters. With the comparative ease of legislation in this country, it may be sufficient to provide for the immediate future.

I. M. RUBINOW

NEW YORK CITY